HOW DIFFERENCES IN STATE POLICY AND LOCAL INSURANCE MARKETS IMPACT THE EFFECTIVENESS OF THE AFFORDABLE CARE ACT'S EXPANSION OF HEALTH INSURANCE ACCESS

by
Christopher Altieri

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ABSTRACT

The Patient Protection and Affordable Care Act relies upon state governments for the implementation of some aspects of its provisions that are designed to expand access to health insurance. Differences in how parts of the law were implemented by state governments, along with different characteristics of the local private insurance market, allow us to measure the effectiveness of these policies and the importance of the private sector's behavior. Previous research has confirmed that the law's Medicaid expansion reduces the uninsured rate among the eligible population. This study expands upon this work through a regression model built on other local characteristics including state policy decisions around the ACA's implementation and differences in the private insurance market. The model finds that the uninsured rate is lower in states which build their own Marketplace for individuals to shop for insurance, as well as in areas with less expensive insurance on the individual Marketplace. These findings have important implications for future policymaking that relies on decision making at the state level or within the private sector.

1. INTRODUCTION

The 2010 Patient Protection and Affordable Care Act (ACA) represented the broadest overhaul of the American health insurance market and social safety net since the passage of Medicare 45 years earlier. Its passage was also highly contentious and politically charged, passed on partisan lines and representing a signature accomplishment of President Obama's first term. The law's significance to both health policy and to the political debate at the time of its passage led to considerable attention to its performance as well as challenges to some aspects of its implementation. A central policy goal of the ACA was the expansion of access to health insurance.

A patchwork of policies was enacted to achieve this goal. All adults are now required to purchase health insurance or face a tax penalty, while health insurance companies are forbidden from denying insurance based on preexisting health conditions. The law has several provisions to help people with paying for insurance under the new mandate depending on their income level. Those with an income below 138% of the poverty line are covered in a nationwide expansion of Medicaid. Those with higher incomes but without coverage can shop for subsidized private plans on health insurance Exchanges built at the state level.

Some of these provisions have faced challenges that have led to inconsistencies in its implementation between different states. The Supreme Court's 2012 ruling in *National Federation of Independent Business v. Sebelius* allowed states to refuse to participate in the Medicaid expansion, which 20 states have done. Additionally, only 22 states built their own Exchanges, with the rest relying on the federal government's infrastructure including the HealthCare.gov website. The Marketplaces where individuals purchase insurance are also dependent upon the activities of private insurance companies. After losing money on the

Exchange health insurance plans when they were first offered in 2014 many private insurers raised their premium prices or removed their plans from the Marketplaces altogether. As a result, many consumers have limited choices when shopping for health insurance on the Exchanges or must pay more for insurance, which could limit the expansion of insurance coverage under the law at this income level.

These variations in the law's implementation across different states afford opportunities to measure the law's effects by comparing what happens where there are differences in its implementation. This is important both for evaluating different policies under the ACA as well as for future policymaking efforts. While prior efforts to expand the social safety net involved universal, sometimes bureaucratic programs available to everyone, such as Social Security and Medicare, the ACA is means tested and involves a patchwork of different policies implemented by state governments and private companies. If such an effort is hurt when states undermine implementation or private companies do not find their participation profitable, then future policymaking should avoid such a structure.

A wide body of research has already found that states which implemented the Medicaid expansion have lower uninsured rates, a finding that this study confirms. This includes increased enrollment among people that previously were eligible for Medicaid, suggesting that the increased publicity and news coverage of the program's expansion leads people to "come out of the woodwork". This effect may hold for other local characteristics related to support for the law or related to its implementation, such as the local political climate or the state government decision to build their own Marketplaces and advertise them.

This study models these differences in state policy, as well as differences in the private insurance market, to measure the impact they have on the uninsured rate for individuals with

an income below 138% of the poverty line, the maximum for Medicaid eligibility under the law. Two models were run using county level data from 2015 and 2016. The analysis finds that, in addition to the Medicaid expansion, a state's decision to build their own Marketplace results in an uninsured rate almost two percentage points higher than in states that do build a Marketplace. Differences in the private insurance market also have a statistically significant effect, as areas with more expensive average premiums lead to a higher uninsured rate. Other variables that were included in the second model, but proved not to have an effect on the uninsured rate, include the state governor's party membership and whether the state's officials joined the legal challenge against the law before the Supreme Court. While much of the opposition to the law was partisan, this suggests that the important factor in states implementing the law is the actual construction of programs such as the Exchanges, rather than softer measures of local attitudes.

These findings confirm the importance of Medicaid in ensuring access to health insurance among low income individuals. It also shows that the insurance Marketplaces are effective at expanding access to private health insurance, but that this can also be harmed when private companies raise prices.

The findings also suggest that constructing the Affordable Care Act in such a way that its success was dependent upon the cooperation of state policymakers and private companies may have hurt the law's effectiveness at expanding health insurance access. Future efforts at expanding the social safety net may be better off with a more traditional program such as Medicare that everyone is eligible for, rather than the patchwork setup of the ACA that has left part of its success dependent upon other self-motivated actors.

2. LITERATURE REVIEW

A wide body of research seeks to measure the effect of different health insurance policies, both in terms of public and private coverage options. Recent work has been focused on the effects of the Affordable Care Act (ACA) and its provisions, particularly because aspects of the law's adoption have varied by state for significant reasons, including whether or not to accept the Medicaid expansion. Examining areas where the law's adoption has varied is a useful way to measure its impact, as researchers can compare its performance in its ability to reduce the uninsured rate depending on what policies have been enacted in a given area. There is also some research prior to the law's passage that bears relevance to current policy, as it tries to measure similar effects but with different laws. Comparing these studies to those done on the Affordable Care Act helps determine the external validity of ACA research to other potential policies made in the healthcare industry or to expand social welfare.

One particularly important pre-ACA piece of research into the effect of Medicaid comes from the Oregon Health Insurance Experiment. Due to budgetary constraints Oregon closed new enrollment into Medicaid in 2004. In 2008 the state determined that it could afford to re-open enrollment, but not for everyone who would sign up, so the state conducted a random lottery to determine who could enroll. This lottery produced a natural, randomized experiment that allowed researchers to measure the effect of Medicaid availability on the population with regards to enrollment, health effects, health utilization, debt levels, and a whole host of other measures. With regards to enrollment, adults in this study who were selected in the random lottery were about 25 percentage points more likely to have health insurance during the study

period than those who were not.[1] Lottery winners were not automatically enrolled in Medicaid, however many chose to do so. The study also found that this was not associated with any "crowding out" effect in the private insurance market,[2] suggesting that Medicaid indeed expands access to health insurance from those that would otherwise go uninsured.

After the ACA was enacted the states of California, Connecticut, Minnesota, and the District of Columbia chose to expand Medicaid earlier than required by the law, so these states became an early source of research into the law's effects. While these states saw increased coverage from Medicaid due to the expansion, some secondary aspects of these expansions became important to keep in mind when examining state effects while implementing the Affordable Care Act. One was that in Connecticut, while there was an increase in Medicaid coverage, there was also a "crowding out" effect on private insurance, where new Medicaid enrollees came not from the uninsured but from those enrolled in private insurance who opted for cheaper coverage.[3] The first to enroll in these states were also the sickest people, most in need of insurance and expensive care.[4] This pattern would later become particularly important when applied nationally to the private insurance Marketplaces, where companies that receive an influx of sick patients are susceptible to high expenses and then needed to change their pricing model.

Another important conclusion from states that expanded early is that coverage increased among populations that were already eligible for Medicaid before its passage, not just

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[1] Finkelstein, Amy, Nathaniel Hendren, and Erzo F. P. Luttmer. The Value of Medicaid: Interpreting Results from the Oregon Health Insurance Experiment. Cambridge (2015): National Bureau of Economic Research. doi:10.3386/w21308. 1057.
[2] Ibid.
[3] Sommers, Benjamin D., Meredith Roberts Tomasi, Katherine Swartz, and Arnold M. Epstein. "Reasons for the Wide Variation in Medicaid Participation Rates among States Hold Lessons for Coverage Expansion in 2014." Health Affairs (Project Hope) 31 (2012): 909-919. doi:10.1377/hlthaff.2011.0977. 84.
[4] Ibid.

those whose income levels meant that it was newly available to them.[5] This "coming out of the woodwork" effect could potentially be attributable to increased publicity for the state Medicaid program due to news coverage, advertising campaigns related to the expansion, and general word of mouth. Some of these factors may be more prominent in some states than others, and if they could be measured could hold some explanatory power over the outcome of states' ACA implementations. One model of the effects of Medicaid expansion found that in non-expansion states citizens of counties closer to the border of another state with the expansion saw greater increases in Medicaid participation.[6] While this study did not explore differences in this effect between states, it is possible that states which are more inclined to support these policies may have a stronger "coming out of the woodwork" effect.

These early states also had wide variation in the take-up rate, which is the percentage of the eligible population that enrolled in health insurance. Generally, states with liberal political leanings, which are more likely to offer generous Medicaid benefits, saw larger enrollment than conservative states. This effect goes away, however, when the generosity of benefits is controlled for, as states with more generous Medicaid benefits such as dental care see higher take-up rates. [7] This suggests that political leanings by themselves are not responsible for differences in take-up rate.

Since the implementation of the Affordable Care Act began in 2014 researchers have been able to more directly measure its effects, including the role of different provisions of the law in expanding coverage. Comprehensive modeling of American Community Survey data has

[5] Ibid., 85.
[6] Clinton, Joshua D., and Michael W. Sances. "The Politics of Policy: The Initial Mass Political Effects of Medicaid Expansion in the States." American Political Science Review 112 (2018). Cambridge University Press: 167–85. doi:10.1017/S0003055417000430. 11
[7] Sommers et. al. "Reasons for the Wide Variation in Medicaid Participation Rates among States Hold Lessons for Coverage Expansion in 2014." 912.

been able to quantify the effects that different policies have at the individual level. The provision of the law most important to reducing the uninsured rate is the Medicaid expansion, which explains about 60% of the reduction, the remainder coming from subsidies offered on insurance premiums for private insurance plans purchased on the Marketplace.[8] About a third of that increase came from the "woodwork effect", which "was evident in all states, whether or not they had expanded Medicaid, and occurred for both adults and children."[9]

Further research has also found that different populations see larger reductions in the uninsured rate due to the Medicaid expansion. Cancer survivors, for instance, see greater coverage gains than adults without a cancer history.[10] This aligns with the earlier research on the first states to expand which found that sicker individuals are more likely to enroll in Medicaid when given an opportunity.[11] Coverage gains are largest among non-Hispanic whites, while weakest among Hispanics.[12]

A great deal of this research has focused on the results of the Affordable Care Act's Medicaid expansion. These effects can be easier to identify, as it only involves one specific income level and one specific public program that is available throughout the country. There are also clear distinctions between states after the Supreme Court allowed some states to opt out of the Medicaid expansion. The individual private insurance market, however, is also an important

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[8] Frean, Molly, Jonathan Gruber, and Benjamin D. Sommers. "Premium Subsidies, the Mandate, and Medicaid Expansion: Coverage Effects of the Affordable Care Act." Journal of Health Economics 53 (2017): 72-86. doi:10.1016. 5

[9] Ibid., 5-6

[10] Davidoff, Amy J., Gery P. Guy, Xin Hu, Felisa Gonzales, Xuesong Han, Zhiyuan Zheng, Helen Parsons, Donatus U. Ekwueme, and Ahmedin Jemal. "Changes in Health Insurance Coverage Associated with the Affordable Care Act among Adults with and without a Cancer History." Medical Care 56 (2018): 220-227. doi:10.1097.

[11] Sommers et. al. "Reasons for the Wide Variation in Medicaid Participation Rates among States Hold Lessons for Coverage Expansion in 2014." 912.

[12] Yue, Dahai, Petra W. Rasmussen, and Ninez A. Ponce. "Racial/Ethnic Differential Effects of Medicaid Expansion on Health Care Access." Health Services Research (2018). doi:10.1111/1475-6773.12834. 8.

pillar of the Affordable Care Act's efforts to expand coverage, and also has a great deal of variation from state to state. These efforts included the creation of the state Marketplaces and setting aside funds for subsidies for insurance premiums to make insurance affordable. Ultimately there became a great deal of state-to-state variation in the implementation of this aspect of the law, as many states chose not to build their own Exchanges and others struggled to have functioning Exchanges in their first year. Further variation comes from differences in the private companies that offer insurance in different areas. This means that consumers face a big difference in the cost of insurance depending on where they live, which could be a source of variation in the uninsured rate.

More generally, qualitative research has shown there is a great deal of state-to-state variation in the private health insurance market to begin with, and this has continued in the Marketplaces. Health insurance is largely dependent upon building a network of health care providers, which is a particularly localized feature.[13] The cost of private insurance is also highly dependent on the cost and availability of these local providers. In areas with a small number of hospitals or providers, particularly rural areas, the lack of competition can force insurers to accept higher provider prices, which in turn get passed on to consumers who purchase insurance.[14] In the case of the Exchanges many of the initial enrollees were sicker, much like in Medicaid expansions, and therefore more expensive to insure, which threw off the pricing models of insurers accustomed to healthier populations in the employer-based insurance market.

[13] Morrisey, M. A., Rivlin, A. M., Nathan, R. P. and Hall, M. A. "Five-State Study of ACA Marketplace Competition: A Summary Report." Risk Management and Insurance Review, 20 (2017): 153-172. doi:10.1111/rmir.12079. 2
[14] Ibid. 4

Many health insurance companies that entered the individual Marketplace found that, partially as a result of these factors, they experienced heavy financial losses on the Exchanges. Aetna and UnitedHealthcare, two of the largest national private insurance companies, withdrew from the Exchanges prior to 2017 after experiencing heavy financial losses.[15] From 2016 to 2017 the number of insurers on the Exchanges fell by half.[16] Some states only have one or two companies offering insurance to individuals on the Exchanges, and limited competition like this could also lead to price increases.

Put together, there are a variety of factors that create state-to-state variation in the private Exchange Marketplaces. There are parts of the country where states have built well-functioning Exchanges with robust competition among insurers which have a wide range of providers to fill their networks. In other states there may be a poorly run Exchange or only one company offering insurance that is only available at high premiums. Research that tries to determine the ACA's impact on the insurance rate has, up until this point, been focused on differences between states due to the Medicaid expansion. Examining the role that these differences in the private individual Marketplaces play could yield more insight into the effects of the law and similar programs, and would also inform future policymaking that could be dependent upon the actions of state governments or private companies.

3. DATA AND METHODS

Two multivariate OLS models were developed consisting of a variety of local factors related to implementation of the Affordable Care Act. The dependent variable in both models was the uninsured rate among individuals whose income was at 138% of the poverty line or

[15] Graves, John A. and Craig Garthwaite. "Success and Failure in the Insurance Exchanges." The New England Journal of Medicine 376 (2017): 907. https://search.proquest.com/docview/1875881528. 907
[16] Ibid.

lower, as measured by the U.S. Census Bureau's American Community Survey (ACS). This part of the population is most sensitive to ACA policies, as it consists of the population eligible for Medicare under the ACA expansion and those most sensitive to differences in the private insurance marketplace. Independent variables come in two broad categories, differences in statewide policies in implementing the Affordable Care Act and differences in characteristics of the private insurance market.

The dataset was compiled on the county level using data from 2015 and 2016. ACS data for 2017 was not available at the time of analysis. This limits the model's ability to measure the effect of the number of health insurance companies, as it was prior to 2017's enrollment that many companies dropped out of the Marketplaces and many counties had just one insurer. The analysis was also conducted looking just at each year, 2015 and 2016, and the outcome did not vary substantially between the two years. Several variables were only available or relevant at the statewide level and therefore did not vary by county.

State-specific characteristics were researched and chosen with the goal of measuring the state's support or hostility towards the law and its implementation. Some of these factors involved the expansion or implementation of programs, including the state's decision on whether to enact the Medicaid expansion or build a local Exchange rather than rely on Healthcare.gov. Other characteristics meant to measure the climate surrounding the law include the party of the state's governor, as a proxy measure of the local political environment, and whether state officials joined the Supreme Court lawsuit challenging the act. While these characteristics all measure some aspect of the state government's feeling towards the law, some may be more relevant than others. It could be that some states were opposed to the law before the Court but did not want to pass up the opportunity at increased Medicaid funds. This

analysis attempts to determine which of these state policy factors is ultimately important in expanding insurance access.

3.1 State Characteristics Compiled for Model

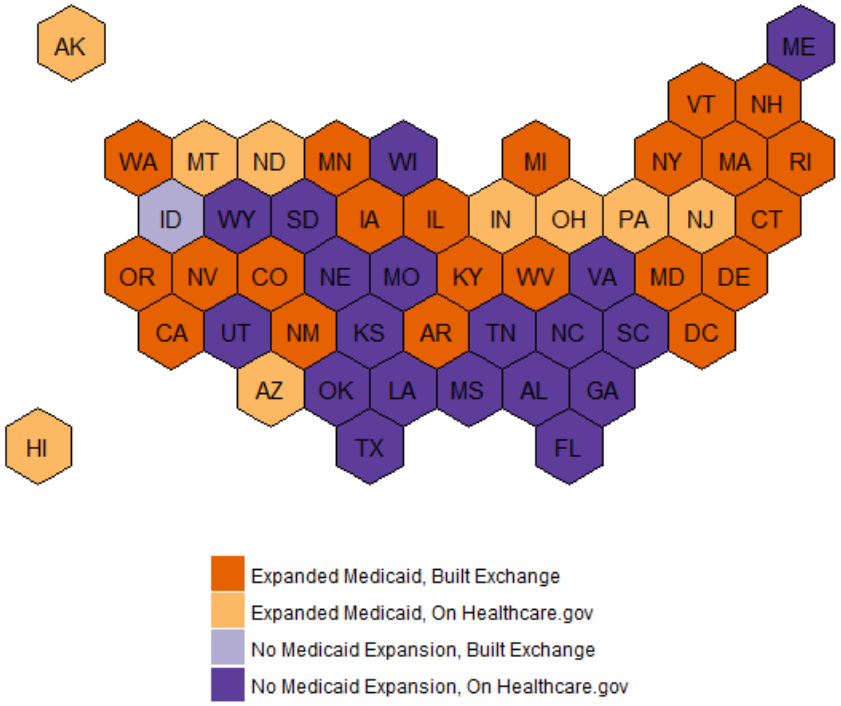
After the passage of the Affordable Care Act and the Supreme Court's decision to allow states to choose not to participate in the law's Medicaid expansion, the extent to which a state could enact aspects of the ACA varied. While the framers of the law originally envisioned each state building their own Exchanges where individuals could buy health insurance, many states opted to let the federal government do it, using the Federally Facilitated Marketplace (FFM) featuring the website, HealthCare.gov. Figure 1 and Table 1 show the distribution of which states chose to expand Medicaid and which built their own Exchanges as of 2016[17].

Before the law's implementation 27 states[18] joined a lawsuit challenging its constitutionality before the Supreme Court. This decision is incorporated into the model as a proxy measure of whether state government supported the law upon its passage and prior to its implementation, which could mean that they were less likely to promote its enaction or provide extensive benefits when doing so.

[17] While Figure 1 and Table 1 depict state policies as of 2016, the regression model's 2015 data varied slightly as Montana only enacted the Medicaid Expansion as of January 1, 2016. Louisiana enacted the expansion as of July 1, 2016, and for the purpose of this analysis was categorized as not expanding, as most enrollment happens at the start of the year. For a full breakdown of these state-specific characteristics see the Appendix.

[18] In Iowa and Washington the Governor and Attorney General joined opposite sides of the lawsuit. For purposes of this analysis they both count as challenging the law.

Figure 1: ACA Participation by State



Source: Kaiser Family Foundation State Health Facts. https://www.kff.org/state-category/health-reform/

Table 1: ACA Participation by State

State Policy Choices	
Expanded Medicaid, Built Exchange	21 states and District of Columbia
Expanded Medicaid, Used Healthcare.gov (FFM)	9 states
No Medicaid Expansion, Built Exchange	1 state
No Medicaid Expansion, Used Healthcare.gov (FFM)	19 states

Partisanship could be another potential factor in the law's support, as it was largely passed on partisan grounds and later became a major campaign topic in the 2010 midterms and 2012 Presidential election. Republican governors who opposed the law in the first place or don't want to see it succeed for political reasons may have done less to promote the new programs than others. To measure this potential partisan effect the dataset includes the party of the state Governor in the measurement year. This was converted to a binary variable with a value of 1 for

Democrats and 0 for Republicans (no state had an Independent or third party governor in the measurement period).

After the law's passage states could also build their own State Based Marketplaces (SBMs) where individuals without insurance from their employer and small business employees could shop for health insurance plans. States that did not do so defaulted to the Federally Facilitated Marketplace (FFM) operated by the Department of Health and Human Services. Some states had a hybrid model of either an SBM on the Federal Platform, where the state performed all functions except for using the Healthcare.gov IT platform, or a State-Partnership Marketplace where the state only managed plans and administered customer service. For the purpose of this analysis and in Figure 1 above the hybrid categories were categorized with State Based Marketplaces; they largely had the same effect on the uninsured rate and separating them out did not meaningfully increase the explanatory power of the model, as demonstrated in Figure 3 in the Results section. A full listing of how all 50 states and the District of Columbia where categorized for these characteristics can be found in the Appendix.

3.2 Private Insurance Market Characteristics

Two aspects of each state's private insurance market were included in the analysis: the monthly cost of insurance premiums and the number of companies offering insurance policies in that county. Premium costs were defined at as the second-least expensive silver metal level premium for a 40-year-old as compiled and analyzed by the Kaiser Family Foundation.[19] This calculation was conducted at the state level and applied to all counties in the state. County level

[19] Premiums can vary drastically according to benefits offered, age, and a host of other potential factors; this measure is designed to capture a "typical" plan available to consumers.

data on premiums is available from the Centers for Medicare and Medicaid Services (CMS) but only for states on the Federally Facilitated Marketplace, so it was not used for this analysis.

A health insurance issuer was defined as a single company offering health insurance on the individual Marketplace, irrespective of the number of individual plans or networks they offered. For example, if Blue Cross offered 5 PPO plans and 8 HMO plans in a county across 4 different metal levels with varying premiums and deductibles, they would still count as just one issuer. These counts were computed using the Robert Wood Johnson Foundation's HIX Compare datasets, which includes data on which health plans are offered in which county on the Exchange Marketplaces across the United States.

4. RESULTS

Two models were produced. Model 2 includes all variables described above, whereas Model 1 only includes variables that are statistically significant at the 95% level. The extra variables found only in Model 2 and therefore without a meaningful effect on the uninsured rate are the partisanship of the state governor and whether the state chose to challenge the Affordable Care Act before the Supreme Court. Neither variable was statistically significant and their inclusion did not meaningfully contribute to the model's explanatory power; the two models have a nearly identical R^2 value of .44. The results of both models is presented in Table 2.

Table 2: Model Coefficients

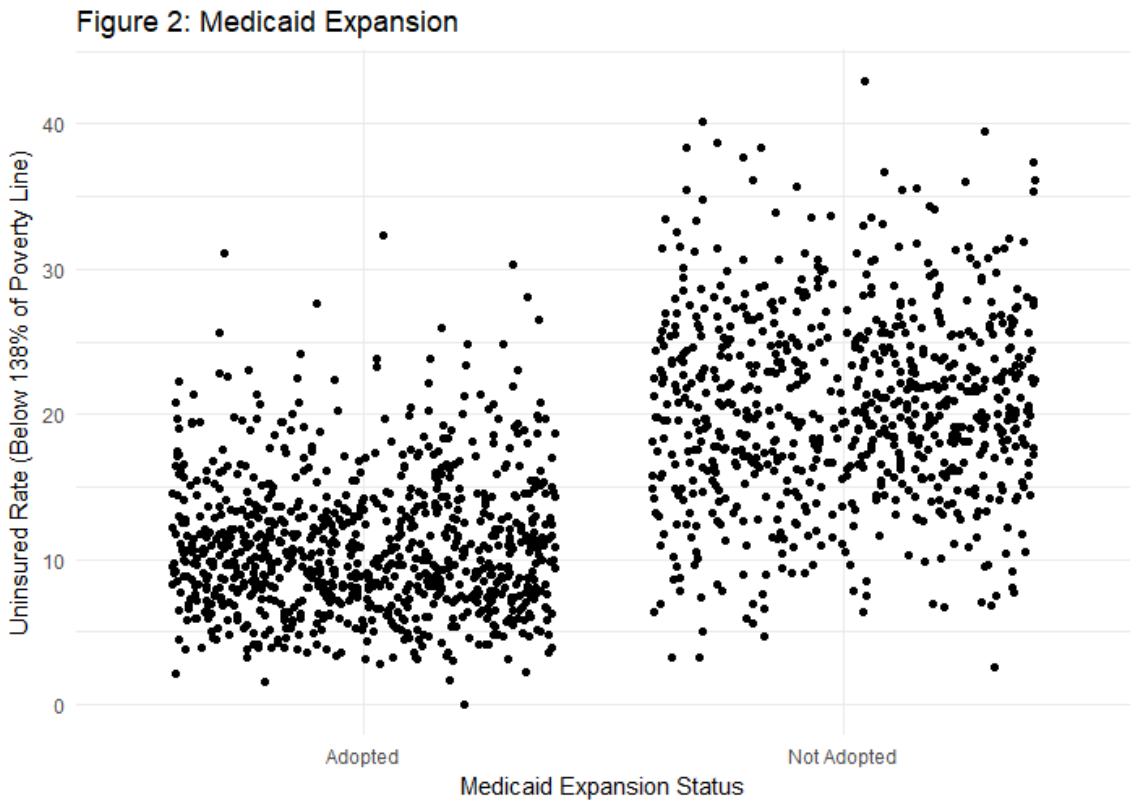
Dependent Variable: Uninsured Rate for Individuals Below 138% of the Poverty Line
N = 1,631
Model 1 R^2= .4375
Model 2 R^2= .4373

Variable	**Model 1 coefficients (p value)**	**Model 2 coefficients (p value)**
Premium Cost †	-.008* (.031)	-.008 (.065)
Number of Health Insurance Issuers	.11** (.006)	.10* (.016)
Did the state expand Medicaid?	-8.43** (0.000)	-8.39** (0.000)
Is state on Federally Facilitated Marketplace? (Healthcare.gov)	1.95** (0.000)	1.79** (0.000)
Did state officials choose to challenge the ACA before the Supreme Court?		0.35 (.27)
Is the state governor a Democrat?		-.04 (.88)
Constant	19.75	19.77

**Coefficient is statistically significant at the 95% level*
*** Coefficient is statistically significant at the 99% level*
†Premium Cost is defined at as the second-lowest cost silver (benchmark) premium for a 40-year-old as compiled and analyzed by the Kaiser Family Foundation.

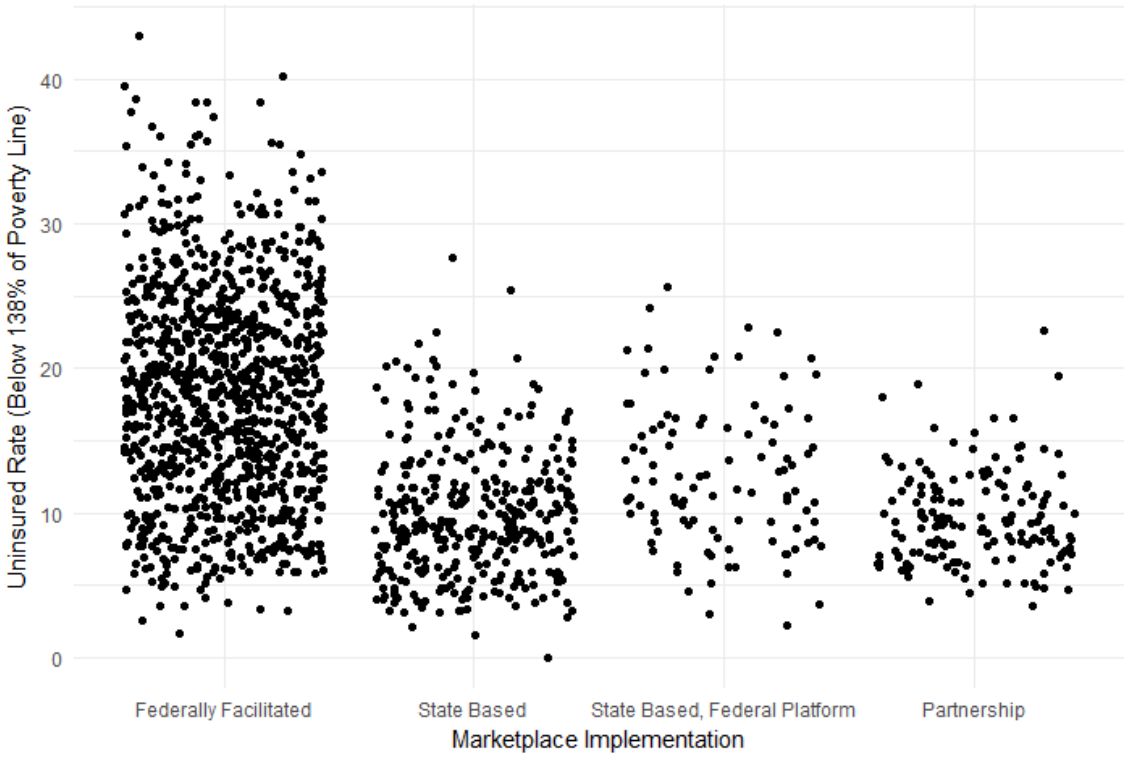
4.1 Impact of State Policy Characteristics

Previous research has shown that the Medicaid expansion is strongly associated with a drop in the uninsured rate, and that conclusion held in this analysis. Enacting the Medicaid expansion meant a drop of 8.4% in the uninsured rate of this population. The uninsured rate by county depending on the state's decision to enact the Medicaid expansion is shown in Figure 2.



In addition to the important role Medicaid plays, states using the Federally Facilitated Marketplace see nearly a 2% higher uninsured rate in the model. Figure 3 compares the uninsured rate for counties in FFM states to those in the other 3 Marketplace categories which involved state government participation.

Figure 3: Type of Insurance Marketplace

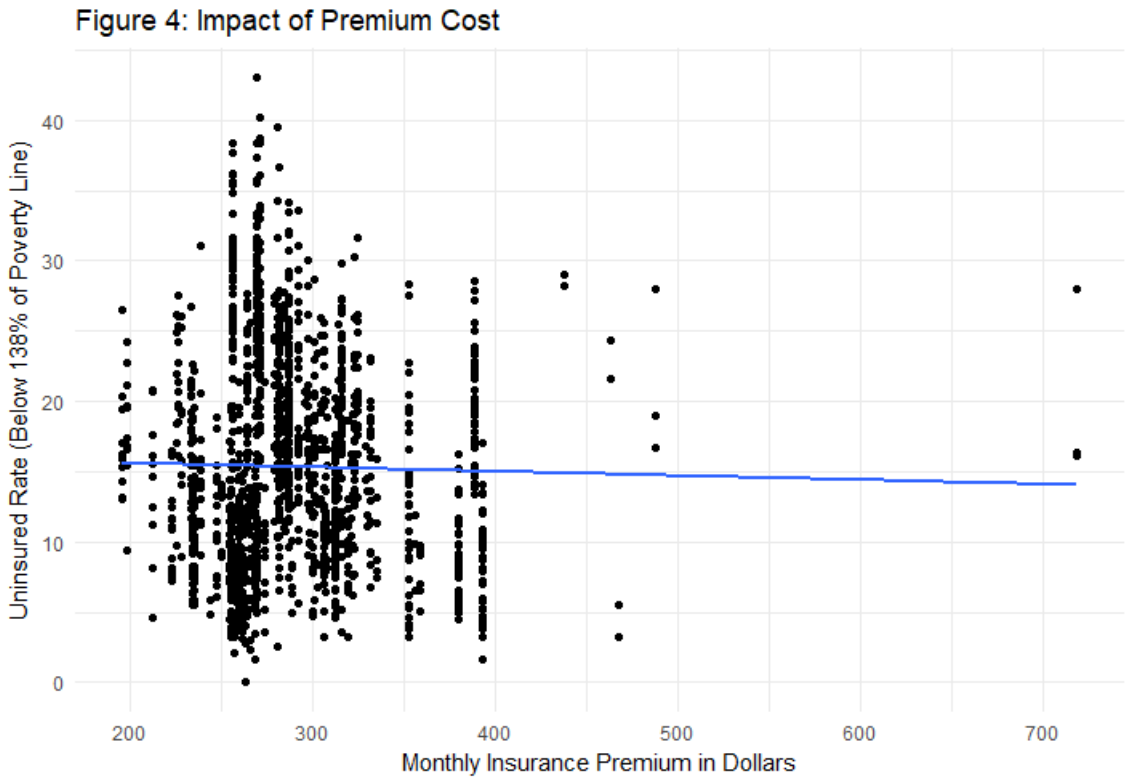


By comparing the two models we can determine which state characteristics mattered the most in reducing the uninsured rate. Ultimately the models show that state decisions to build or expand programs had a real effect to bring down the uninsured rate. Both of these variables involve an active expansion of the state government, with funding and a marketing effort to bring a new service to the population. The other variables considered in Model 2, while they may correlate with these factors and be a signal of the local political environment and attitudes surrounding the law, do not ultimately matter regarding the state's ability to expand insurance.

4.2 Impact of Private Insurance Market Characteristics

Both private market variables had a significantly significant impact on the uninsured rate at the 95% confidence interval, but with a less significant relationship than the state policy

variables. The model found that a $100 increase in monthly premiums leads to a 0.8% increase in the uninsured rate. Figure 4 is a scatterplot of this relationship. A few counties are outliers with significantly higher premiums. These are all located in Alaska, where healthcare is significantly more expensive than in the rest of the country.



Counties with more issuers saw a higher uninsured rate. This is somewhat counterintuitive, as more issuers would imply more competition in the individual market. This relationship may not hold, however, should this analysis be conducted using data from 2017, when many counties only one or no issuers offering insurance, when it becomes available. Such monopoly situations could lead to substantially higher costs that could increase the uninsured rate in these areas.

5. CONCLUSION

This model demonstrates that the decisions that state governments made in implementing the Affordable Care Act played an important role in how effective it was at expanding access to health insurance. A state that chose to both expand Medicaid and build its own Exchange Marketplace would, according to the model, see its uninsured rate among poor citizens drop by over 10%. Both policies are shown to be effective ways to expand access to health insurance.

In many states these were politically charged decisions, with some Republican governors going against party doctrine to institute one or both policies. Comparing these two models demonstrates that instituting these programs worked to expand insurance access, regardless of the local political environment. This finding agrees with earlier research which found that political factors had no impact on the take up rate for health insurance factors around the generosity of benefits were controlled for.

The availability of private insurance is another source of variation in people's ability to access health insurance after the passage of the Affordable Care Act. Prior to 2017 many health insurance companies, including two of the largest companies in UnitedHealthcare and Aetna, dropped out of the Marketplaces. Many places now have only one insurer with an effective monopoly on the individual Marketplace. Unfortunately, this analysis could not explore the effect that this shift had, as county level American Community Survey data was only available through 2016. This analysis was also limited in its ability to fully capture the potential price and monopolist effects from the private insurance market as there is no clean dataset on this market available for the entire country. While the Centers for Medicare and Medicaid Services does

publish clean datasets on all plans offered on Healthcare.gov, this is limited to states in the Federally Facilitated Marketplaces and therefore limits comparisons to other states.

Ultimately this analysis found that more insurers actually increase the uninsured rate. It's possible that this effect would go away or be reversed when data from 2017 and 2018 is included with many examples of counties with one or no insurers. It's also possible that with the inclusion of cost in the analysis this effect would go away, as that would capture monopolists' potential price increases.

Still, this analysis shows that private market factors, including price, do impact the uninsured rate, which speaks to the important consideration of the law's reliance upon private companies in attempting to expand insurance access. Alternative proposals at the time of the laws passage included expansions of Medicare and including a government sponsored health insurance plan on the individual Marketplaces. These policy options would have left ACA supporters less reliant upon the private market to expand insurance access. Future efforts to expand insurance coverage and the social safety net would do well to keep this in mind when considering different policy options.

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APPENDIX: STATE CHARACTERISTICS USED IN MODEL

State	**Supreme Court Case Position**	**Type of Exchange Marketplace**	**Medicaid Expansion**	**Governor's Party**
Alabama	Challenged	Federally-facilitated Marketplace	Adopted	Republican
Alaska	Challenged	Federally-facilitated Marketplace	Adopted in 2016	Democrat
Arizona	Challenged	Federally-facilitated Marketplace	Adopted	Democrat
Arkansas	No position	State-based Marketplace-Federal Platform	Adopted	Democrat
California	Supported	State-based Marketplace	Adopted	Republican
Colorado	Challenged	State-based Marketplace	Adopted	Republican
Connecticut	Supported	State-based Marketplace	Adopted	Democrat
Delaware	Supported	State-Partnership Marketplace	Adopted	Republican
District of Columbia	Supported	State-based Marketplace	Adopted	Democrat
Florida	Challenged	Federally-facilitated Marketplace	Not Adopted	Republican
Georgia	Challenged	Federally-facilitated Marketplace	Not Adopted	Republican
Hawaii	Supported	Federally-facilitated Marketplace	Adopted	Democrat
Idaho	Challenged	State-based Marketplace	Not Adopted	Republican
Illinois	Supported	State-Partnership Marketplace	Adopted	Republican
Indiana	Challenged	Federally-facilitated Marketplace	Adopted	Republican
Iowa	Challenged and Supported	State-Partnership Marketplace	Adopted	Republican
Kansas	Challenged	Federally-facilitated Marketplace	Not Adopted	Republican
Kentucky	No position	State-based Marketplace-Federal Platform	Adopted	Republican
Louisiana	Challenged	Federally-facilitated Marketplace	Not Adopted	Democrat
Maine	Challenged	Federally-facilitated Marketplace	Not Adopted	Republican
Maryland	Supported	State-based Marketplace	Adopted	Republican
Massachusetts	Supported	State-based Marketplace	Adopted	Republican
Michigan	Challenged	State-Partnership Marketplace	Adopted	Republican
Minnesota	No position	State-based Marketplace	Adopted	Democrat

Mississippi	Challenged	Federally-facilitated Marketplace	Not Adopted	Republican
Missouri	No position	Federally-facilitated Marketplace	Not Adopted	Republican
Montana	No position	Federally-facilitated Marketplace	Adopted in 2016	Democrat
Nebraska	Challenged	Federally-facilitated Marketplace	Not Adopted	Republican
Nevada	Challenged	State-based Marketplace-Federal Platform	Adopted	Republican
New Hampshire	No position	State-Partnership Marketplace	Adopted	Republican
New Jersey	No position	Federally-facilitated Marketplace	Adopted	Democrat
New Mexico	Supported	State-based Marketplace-Federal Platform	Adopted	Republican
New York	Supported	State-based Marketplace	Adopted	Democrat
North Carolina	No position	Federally-facilitated Marketplace	Not Adopted	Democrat
North Dakota	Challenged	Federally-facilitated Marketplace	Adopted	Republican
Ohio	Challenged	Federally-facilitated Marketplace	Adopted	Republican
Oklahoma	No position	Federally-facilitated Marketplace	Not Adopted	Republican
Oregon	Supported	State-based Marketplace-Federal Platform	Adopted	Democrat
Pennsylvania	Challenged	Federally-facilitated Marketplace	Adopted	Democrat
Rhode Island	No position	State-based Marketplace	Adopted	Democrat
South Carolina	Challenged	Federally-facilitated Marketplace	Not Adopted	Republican
South Dakota	Challenged	Federally-facilitated Marketplace	Not Adopted	Republican
Tennessee	No position	Federally-facilitated Marketplace	Not Adopted	Republican
Texas	Challenged	Federally-facilitated Marketplace	Not Adopted	Republican
Utah	Challenged	Federally-facilitated Marketplace	Not Adopted	Republican
Vermont	Supported	State-based Marketplace	Adopted	Republican
Virginia	Challenged	Federally-facilitated Marketplace	Not Adopted	Democrat
Washington	Challenged and Supported	State-based Marketplace	Adopted	Democrat
West Virginia	No position	State-Partnership Marketplace	Adopted	Republican
Wisconsin	Challenged	Federally-facilitated Marketplace	Not Adopted	Republican
Wyoming	Challenged	Federally-facilitated Marketplace	Not Adopted	Republican

CURRICULUM VITA

Christopher Altieri was born in Massachusetts in 1992. He earned a Bachelor's of Science in Economics with a second major in Political Science and a concentration in American Government from American University in 2014. Since 2014 he has worked as a Research Associate in the Health Research Group of the Center for the Study of Services, conducting survey research for a variety of stakeholders in the health industry including health plans and physician organizations. He will complete his Masters of Science in Government Analytics from Johns Hopkins University in December 2018.